Coding Dementia

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by Roz Laakso, RHIT, CCS-P

Dementia is defined as "a deterioration of intellectual function and other cognitive skills, leading to a decline in the ability to perform activities of daily living."[1] Alzheimer's disease is an age-related, irreversible brain disorder that occurs gradually and results in memory loss, behavior and personality changes, and a decline in thinking abilities. It is the most common cause of dementia in the United States in older people.

In 1995 my husband was diagnosed with multi-infarct dementia, a related condition to Alzheimer's disease. As caregiver, I spent many years trying to come to grips with this devastating disease and trying to learn to cope with it. As a coder, I was very interested in learning how to properly code the condition. Correct coding of dementias is important, especially in the long-term care setting.

Request for New Codes

Previously, general dementia or Alzheimer's disease diagnoses ignored established criteria and did not allow tracking of specific types of dementia such as dementia with Lewy bodies (DLB), which is the second largest cause of neurodegenerative dementias in the elderly.

In December 2002 the American Academy of Neurology requested new ICD-9-CM codes for dementia with Lewy bodies and frontotemporal dementia. These additions were requested because dementia classification has expanded with new knowledge of pathology and pathophysiology, and dementia and geriatric specialists are increasingly using new terms to describe their patients.

In 2003 new ICD-9-CM codes were added to further expand existing codes describing this condition. These include:

- 331.82, Dementia with Lewy bodies
- 331.19, Frontotemporal dementia

With subcategory 294.1, Dementia in conditions classified elsewhere, coders are instructed to code first any underlying physical condition. This note is applicable with the following codes:

- Alzheimer's disease (331.0)
- Cerebral lipidoses (330.1)
- Dementia with Lewy bodies (331.82) (newly added)
- Dementia with Parkinsonism (331.82) (newly added)
- Epilepsy (345.0–345.9)
- Frontal dementia (331.19) (newly added)
- Frontotemporal dementia (331.19)
- General paresis [syphilis] (094.1)
- Hepatolenticular degeneration (275.1)
- Huntington's chorea (333.4)
- Creutzfeldt-Jakob disease (046.1)
- Multiple sclerosis (340)
- Pick's disease of the brain (331.11) (revised)
- Polyarteritis nodosa (446.0)
- Syphilis (094.1)

The correct interpretation of this note is important in correct code assignment since the sequencing is specified. The underlying physical condition is sequenced before the dementia code. Any behavioral disturbance associated with these dementias is reported separately using the appropriate code (294.10–294.11).

To correctly assign codes, it is helpful for the coder to understand the differences in the above-mentioned conditions.

Dementia with Lewy Bodies

Dementia with Lewy bodies (331.82) is a dementia with Parkinsonian motor features. Unexplained falls are a predominant early feature. Pathologically, it differs from Parkinson's disease in that the Lewy body intracellular inclusions are also found frontally, not just within the basal ganglia. This cerebral degeneration is also manifest by somewhat greater neuropsychiatric features than Alzheimer's with more prominent hallucinations. Patients with this form of dementia classically may worsen with phenothiazine-like medications, which are used for psychoses.

Dementia with Lewy bodies is clinically defined by the presence of dementia, prominent hallucinations and delusions (yet sensitive to antipsychotic medications), fluctuations in alertness, and gait or balance disorder.[2] This type of dementia accounts for 20 to 30 percent of degenerative dementias and is second in occurrence behind Alzheimer's disease. The age of onset for dementia with Lewy bodies is comparable to Alzheimer's disease. Men are more susceptible (1.5:1) and have worse prognoses. The duration may be rapid (one to five years) or typical to Alzheimer's disease:

There are areas where DLB differs from the other codes including Alzheimer's disease, Parkinson's disease, and dementia:

- **Alzheimer's disease**—early hallucinations, fluctuation in alertness, and sensitivity to neuroleptics are important to differentiate.
- **Parkinson's disease and dementia**—dementia with Parkinson's disease is subcortical with different symptoms.

Frontotemporal Dementia

Frontotemporal dementia (331.19) differs from Alzheimer's disease by its frontal lobe personality changes, such as:

- Impulsivity
- Disinhibition
- Motor impersistence
- Loss of social awareness
- Lack of attention to personal hygiene

Language can be affected in frontotemporal dementia, and other cognition may not be as impaired as in Alzheimer's disease. One subset of frontotemporal dementia is Pick's disease, which has its own code (331.11).

Assigning the Codes

In long-term care situations it is sometimes difficult to determine when to use codes for dementia alone as a basis for whether a covered stay is reasonable and necessary, because the code for dementia alone does not define the extent of a resident's cognitive impairment. For example, a claim submitted with only a diagnosis of Alzheimer's disease (331.0) may entitle a resident to evaluation and management visits and therapies if the payer determines that these therapies are reasonable and necessary when reviewed in the context of a resident's overall medical condition. Therefore, coders should also be instructed to classify all secondary diagnoses or conditions that most closely reflect the medical necessity of the billed service.

When sequencing these conditions, it is imperative to follow official coding guidelines and to determine the primary reason for care. For example, when a provider uses physical therapy to treat a patient for the purpose of rehabilitation, multiple underlying conditions may need to be listed as additional codes. See the note with category V57 that states, "Use additional code to identify underlying conditions."

In addition to code V57.1, a patient with an unsteady gait due to Alzheimer's dementia would have two codes assigned. ICD-9-CM codes 311.0, Alzheimer's disease and code 781.2, Abnormality of gait would be assigned as secondary diagnoses to

support the medical necessity of the physical therapy service. Conversely, when the care is focused on the Alzheimer's disease and not rehabilitation, then code 331.0, Alzheimer's disease would be reported as the primary code.

When a beneficiary with dementia experiences an illness or injury unrelated to their dementia, the provider should submit a claim with a primary diagnosis that most accurately reflects the need for the provided service. For example, following a hip replacement in a patient with Alzheimer's disease, a physical therapy provider with a focus on rehabilitation should submit a claim using ICD-9-CM code V57.1, Other physical therapy, V54.81, Aftercare following joint replacement, V43.64, Hip joint replacement by artificial or mechanical device or prosthesis, and 331.0, Alzheimer's disease. Alzheimer's disease would not be the primary diagnosis in this case.

If the type of dementia is documented, then the specific code should be assigned, such as dementia, with Lewy bodies (331.82) or frontotemporal dementia (331.19).

Diagnosing Alzheimer's Disease

Unfortunately, there is no simple diagnostic test that can detect if a person has Alzheimer's disease. The diagnosis is made by reviewing a detailed history on the person and the results of several tests, including a complete physical and neurological examination, a psychiatric assessment, and laboratory tests. Once these tests are completed, a diagnosis of "probable" Alzheimer's disease can be made by process of elimination.

However, physicians can be 80 to 90 percent certain their diagnosis is accurate. The process may be handled by a family physician or may involve a diagnostic team of medical professionals, including the primary physician, neurologist, psychiatrist, psychologist, and nurses.

The diagnostic process could be lengthy and is usually performed on an outpatient basis. It may involve going to several different locations or even to a specialized Alzheimer diagnostic center. Since Alzheimer's disease is the most common cause of dementia, it is important to identify the actual cause in order to code the condition appropriately.

Many things can cause dementia, such as depression, drug interaction, and thyroid problems, and may be reversible if detected early. Other causes of dementia include strokes, Huntington's disease, Parkinson's disease, and Pick's disease.

Clearly the addition of new codes to further classify dementia will be vital in the accuracy of data collection as clinicians and researchers learn more about this ever-growing health hazard.

Notes

1. *The Merck Manual of Geriatrics*. Available online at www.merck.com/mrkshared/mm_geriatrics/sec5/ch40.jsp.
2. McKeith, I.G., et al. "Consensus Guidelines for the Clinical and Pathologic Diagnosis of Dementia with Lewy Bodies (DLB): Report of the Consortium on DLB International Workshop." *Neurology* 47 (1996): 1113–24.

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Roz Laakso *(rlaakso@ericksonmail.com) is director of coding and compliance at Erickson Retirement Communities in Catonsville, MD.*

Article citation:
Laakso, Roz. "Coding Dementia." *Journal of AHIMA* 75, no.9 (October 2004): 84-88.